



FRAUD AND ABUSE IN WYOMING'S AGING MEDICAID POPULATION

Wyoming Medicaid Fraud
Control Unit
May 20, 2009

Wyoming Conference on Aging
by
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MFCU Investigator

OVERVIEW

- Health Care Fraud History/Overview
- Responsible Parties
 - Medicaid Fraud Control Unit (MFCU)
 - Medicaid Agency
 - Other
- Referrals to the MFCU / MFCU Cases
 - Financial Fraud and Abuse
 - Abuse, Neglect and Exploitation
 - Recipient Fraud
- Contacts / Resources

DIFFERENCES IN MEDICAID AND MEDICARE

- ◉ **Medicaid:** Title XIX of Social Security Act. State administered and federally monitored financing of medical services for individuals in financial need.
- ◉ **Medicare:** Title XVIII of Social Security Act Federally funded health care program primarily focused on the aged population.
- ◉ **Medicare** = care for the elderly
Medicaid = aid for the needy

TIMELINE

THE HISTORY OF HEALTH CARE FRAUD AND ABUSE LAWS

- 1863 - False Claims Act
- 1965 - Social Security Amendments
- 1972 - Social Security Act of 1972
- 1977 - Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977
- 1978 - Inspector General Act
- 1980 - Omnibus Budget Reconciliation Act of 1980
- 1981 - Omnibus Budget Reconciliation Act of 1981
- 1986 - False Claims Act Amendments of 1986
- 1986 - Program Fraud Civil Remedies Act of 1986
- 1987 - Medicare and Medicaid Patient Program Protection Act
- 1989 - Omnibus Budget Reconciliation Act of 1989
- 1993 - Omnibus Budget Reconciliation Act of 1993
- 1994 - Government Management Reform Act
- 1996 - Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- 1997 - Balanced Budget Act of 1997 (BBA)
- 2006 - Deficit Reduction Act of 2005
- 2007 - Updates to Wyoming Vulnerable Adult Abuse Statutes

IS THERE FRAUD OR ABUSE IN
WYOMING?

Unfortunately...

Yes !

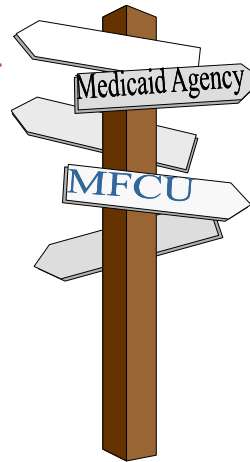
A background image showing several US dollar bills, including a \$100 bill and a \$20 bill, overlapping each other. The bills are slightly faded and tilted.

1. Increased medical costs to
EVERYONE

2. Fewer \$ resources available
to those in need

WHO IS RESPONSIBLE FOR WHAT?

- I. Medicaid Fraud Control Unit (MFCU)
- II. State Medicaid Agency
- III. CMS
- IV. HHS/OIG
- V. DFS
- VI. Law Enforcement



THE MEDICAID FRAUD CONTROL UNIT (MFCU)



WHAT IS A MEDICAID FRAUD CONTROL UNIT (MFCU)?

- Nomenclature: MFCU
- History:
 - Omnibus Budget Reconciliation Act (OBRA) '93
 - Established by 42 CFR §1007.3
 - Actions to Establish Wyoming MFCU
 - January 1, 1995: Wyoming MFCU became operational

WHAT IS THE ROLE OF THE MEDICAID FRAUD CONTROL UNIT?

- ✓ Subdivision of Attorney General's Office
- ✓ Work closely with Law Enforcement
 - Cross-designated
 - Division of Criminal Investigation
 - U.S. Attorney's Office
 - Prosecuting Attorneys
- ✓ Distinct from Medicaid Agency
- ✓ Oversight responsibilities of State agencies handling Medicaid dollars
- ✓ Distinct from PRICE
- ✓ Overlap functions of Adult Protective Services



MEDICAID FRAUD CONTROL UNIT MISSION STATEMENT

“Receive allegations of fraud in the Medicaid Program, of **abuse or neglect of patients** in Medicaid-funded facilities, and of misappropriation of patients’ funds; investigate allegations and, when appropriate, prosecute or assist in the prosecution of such cases; work with federal, state and local agencies, prosecutors and law enforcement to provide training and develop mechanisms for the effective detection and prosecution of Medicaid fraud in Wyoming.”

MFCU STAFFING REQUIREMENTS

- One or more attorneys
- One or more auditors
- A senior investigator

[42 CFR §1007.13 - Staffing Requirements]

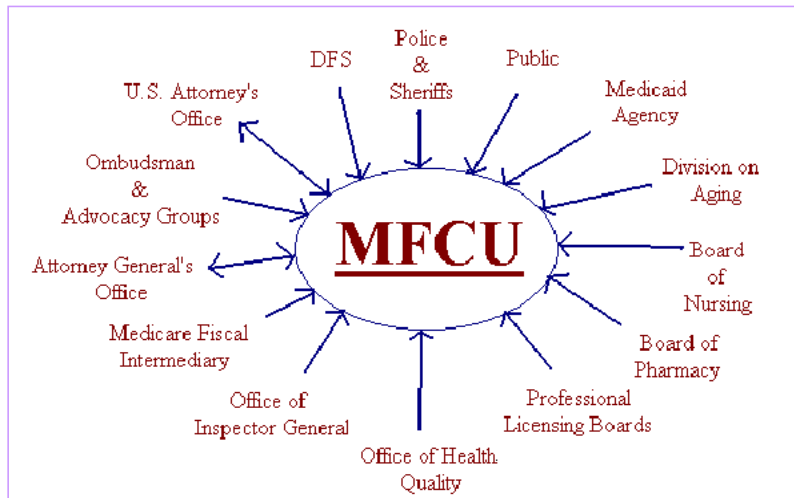
OTHER GUARDIANS AGAINST FRAUD AND ABUSE: LEGISLATORS, REGULATORS & ENFORCERS

- Congress
- Department of Health and Human Services (HHS): Centers for Medicare and Medicaid Services (CMS)
- HHS: Office of Inspector General (OIG)
- Department of Justice (DOJ) Criminal, Civil, and Antitrust Divisions
- DOJ: Federal Bureau of Investigation (FBI)
- Medicare Contractors
- Peer Review Organizations (PROs)
- Department of Labor (DOL)
- Department of Veterans Affairs

OTHER GUARDIANS AGAINST FRAUD AND ABUSE: LEGISLATORS, REGULATORS & ENFORCERS CONTINUED . . .

- State Department of Family Services
- Other Federal Agencies
 - U.S. Postal Inspection Service
 - U.S. Office of Personnel Management
 - Federal Trade Commission's Bureau of Consumer Affairs
 - Railroad Retirement Board
 - Internal Revenue Service
- State Attorneys General
- Data Banks
 - Health Integrity and Protection Data Bank (HIPDB)
 - DFS Central Registry
- Private Payors
- Private Citizens

SOURCES OF REFERRALS AND INFORMATION.



Referral Sources
ANY PERSON WHO IS IN
DIRECT CONTACT WITH A
MEDICAID PROVIDER
OR RECIPIENT.



WHAT MAKES A “GOOD” REFERRAL?

- Has a Medicaid nexus
- Made in a timely manner
- Contains sufficient detail to allow investigation to begin
 - Identification of reporting party
 - Identification of suspect
 - Identification of victim
- Contains references to possible violations of law, rule or policy

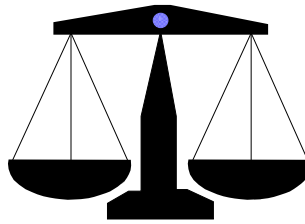
WHAT MAKES A “GOOD” REFERRAL? CONTINUED . . .

- Includes possible sources of additional information
- Includes identified overpayment amounts*
- See Incident Report / Case Referral form

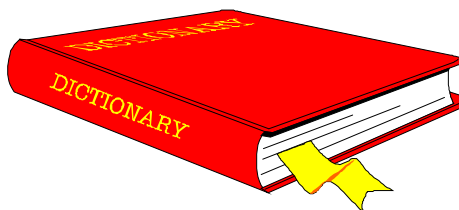
HIERARCHY OF LAW

Federal and State:

- Constitution
- Statutes
- Rules
- Provider Manuals
- Policies
- Provider operation manuals; compliance plans

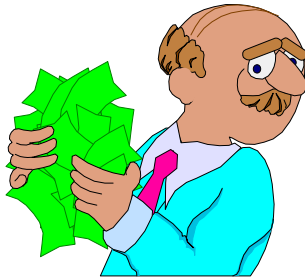


DEFINITIONS - FINANCIAL ISSUES



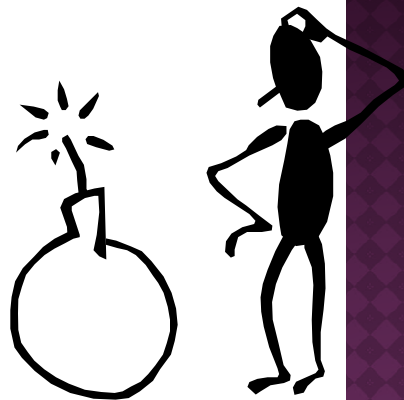
FRAUD:

An **intentional** deception or misrepresentation made by an individual with the knowledge that the deception or misrepresentation may result in excess payment.

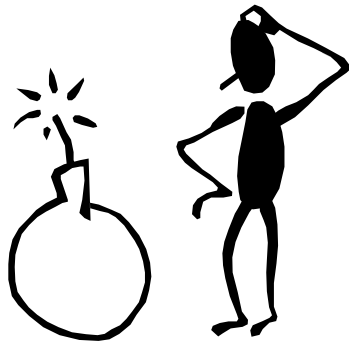


BILLING FRAUD

- Generally, includes any verbal or written lie that forms the basis of any billing for services or benefits in the Medicaid system.
- Can be perpetrated by any provider.



BILLING FRAUD



- Billing fraud includes, but is not limited to:
- Billing for services not rendered or documented
- Double billing
- Upcoding

FRAUD

Four factors distinguish fraud:

- 1. A false misrepresentation: **THE LIE**.
- 2. **The lie** is intentional or knowingly made.
- 3. **The lie** is made to obtain a benefit not due to the claimant.
- 4. **The lie** is material. i.e.: it will make a difference in the benefits received.

EXAMPLES OF RECENT NATIONAL COLLUSION AND FRAUDULENT SCHEMES.

EXAMPLES:

Ambulance Service vs. Simple Transport.	Billing for services not rendered.	False physician or nursing notes.
X-ray & labs not needed or not done – “Lab Dumping.”	“Gold Pill” – Prescribing narcotics and selling back for street value.	Fraudulent credentials, licenses, clinics, providers.
Unnecessary transportation.	Selling Medicaid ID card or number.	Drug diversion schemes.

EXAMPLES OF RECENT WYOMING COLLUSION AND FRAUDULENT SCHEMES.

EXAMPLES

Billing for non-covered services.	Billing for services not rendered.	Re-sale of Medicaid provided durable medical equipment.
Unbundling.	Facility use of Patient Trust Funds for personal use.	Sub-standard quality of care.
Billing at a higher rate than applicable.	Upcoding.	Billing for services that are not medically necessary or therapeutically essential.

TYPICAL INVESTIGATIVE ACTIVITIES

1. Receive referral
2. Verify reporting party
3. Establish type of report
 - Fraud/Financial Abuse
 - Abuse/Neglect
 - Patient Funds
4. Verify identification of reported suspect
5. Establish Medicaid nexus
6. Contact other law enforcement agencies
7. Contact other State Agencies or Boards
8. Research laws, rules, policies & procedures
9. Obtain documentation
10. Conduct criminal background check

INVESTIGATION TACTICS MAY INCLUDE:

- | | |
|--|---|
| <ul style="list-style-type: none">● Interview of health care professionals and employees● Document review and analysis● Extensive report writing● Informant development | <ul style="list-style-type: none">● Limited use of undercover agents● Surveillance● Search and arrest warrants● Grand Jury subpoena and testimony● Creation and use of exhibits at trials |
|--|---|

WHO MAY PERFORM AN INVESTIGATION?

- In general, a provider receiving Medicaid funds may be audited by any governmental entity in the pipeline through which Medicaid funds have passed, including:
 - Health and Human Service's (HHS), Office of the Inspector General (OIG);
 - Centers for Medicare and Medicaid Services (CMS);
 - Wyoming Department of Health, Office of Medicaid; and
 - Wyoming Medicaid Fraud Control Unit (MFCU).

WHAT ABOUT CONFIDENTIALITY DURING THE INVESTIGATIVE PROCESS?

- The Wyoming MFCU is an exempt entity under the Health Insurance Portability and Accountability Act (HIPAA) and is therefore authorized to receive any and all healthcare and/or billing/payment information regarding Medicaid recipients

RECORD ACCESS

The variety of records to which the MFCU has access includes but is not limited to:

- ❖ Hospital records;
- ❖ Nursing charts;
- ❖ Specialized service records, i.e. therapy, dietary, medication, etc.; and
- ❖ Progress notes.

WHAT ARE THE CONSEQUENCES OF MFCU INVESTIGATIVE FINDINGS?

- If there is no apparent violation of statutes or regulations and there is no excess payment, no action will be taken as a consequence of the audit.
- If there is an overpayment, either Medicaid or the MFCU will take action to recoup.
- If it appears the provider has violated criminal laws, the case will be investigated and a decision regarding prosecution will be made.

WHAT ARE THE PENALTIES?

- Medicaid fraud
- Obtaining property by false pretenses
- Falsification of records (under the federal False Claims Act)

WHAT ARE THE PENALTIES? CONTINUED...

- The federal False Claims Act prohibits **falsification of records** and allows the collection of costs of prosecution plus treble damages against one who:
 - knowingly presents to the Government a false or fraudulent claim for payment or approval;
 - knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved; or
 - conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

OTHER POSSIBLE CONSEQUENCES OF FRAUD

- Criminal charges e.g. larceny
- Sanctions
- Exclusion from Medicaid (and/or Medicare)



ABUSE, NEGLECT AND EXPLOITATION



SELECTED DEFINITIONS

Wyoming Statute § 35-20-102

- **“Abuse”** means the intentional or reckless infliction, by the vulnerable adult’s caregiver, family member or other individual of:
 - Injury;
 - Unreasonable confinement which threatens the welfare and well being of a vulnerable adult; or
 - Intimidation or cruel punishment with resulting physical or emotional harm or pain to a vulnerable adult.

SELECTED DEFINITIONS CONTINUED...

- **“Vulnerable Adult”** means any person eighteen (18) years of age or older who is unable to manage and take care of himself or his property without assistance as a result of advanced age or physical or mental disability;

SELECTED DEFINITIONS CONTINUED...

- **“Exploitation”** means the reckless or intentional act taken by any person, or any use of the power of attorney, conservatorship or guardianship of a vulnerable adult, to obtain control through deception, harassment, intimidation or undue influence over the vulnerable adult’s money, assets or property with the intention of permanently or temporarily depriving the vulnerable adult of the ownership, use, benefit or possession of his money, assets or property;

SELECTED DEFINITIONS CONTINUED...

- **“Capacity to consent”** means the ability to understand and appreciate the nature and consequences of making decisions concerning one’s person, including, provisions for health or mental health care, food, shelter, clothing, safety or financial affairs. This determination may be based on assessment or investigative findings, observation or medical or mental health evaluations;

SELECTED DEFINITIONS CONTINUED...

- **“Neglect”** means the deprivation of or failure to provide, including self-deprivation, of the minimum food, shelter, clothing, supervision, physical and mental health care, and other care necessary to maintain a vulnerable adult’s life or health, or which may result in a life-threatening situation.

SELECTED DEFINITIONS CONTINUED...

- **“Mental disability”** means a condition causing mental dysfunction resulting in an inability to manage resources, carry out the activities of daily living or protect oneself from neglect, abuse, exploitation or hazardous situations without assistance from others. Whether or not a mental dysfunction of such degree exists is subject to an evaluation by a licensed psychologist, psychiatrist or other qualified licensed mental health professional or licensed physician, if disputed;

MANDATORY REPORTING:

Wyoming Statute § 35-20-103

- a) Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the department.

MANDATORY REPORTING: CONTINUED...

Anyone who in good faith makes a report pursuant to this section is immune from civil liability for making the report.



DUTY TO REPORT

Wyoming Statute § 35-20-111

- The duty to report imposed by W.S. 35-20-103 applies without exception to a person or agency who knows, or has sufficient knowledge which a prudent and cautious man in similar circumstances would have to believe, that a vulnerable adult has been or is being abused, neglected, exploited or abandoned, or is committing self neglect, and knowingly fails to report in accordance with this act is guilty of a misdemeanor punishable by imprisonment for not more than one (1) year, a fine of not more than one thousand dollars (\$1000.00), or both.

PENALTIES:

Wyoming Statute § 6-2-507

- a) **Except under circumstances constituting a violation of §W.S. 6-2-502, a caregiver is guilty of abuse, neglect, abandonment or exploitation of a vulnerable adult if the caregiver intentionally or recklessly abuses, neglects, abandons or exploits a vulnerable adult.**
- b) **Reckless abuse, neglect or abandonment of a vulnerable adult is a misdemeanor, punishable by not more than one (1) year in jail, a fine of one thousand dollars (\$1,000.00), or both, and registration of the offender's name on the central registry.**

PENALTIES CONTINUED...

- c) **Intentional abuse, neglect or abandonment** of a vulnerable adult is a felony punishable by not more than ten (10) years in prison, a fine of not more than ten thousand dollars (\$10,000.00), or both, and registration of the offender's name on the central registry.

PENALTIES CONTINUED...

- **Exploitation** of a vulnerable adult is a felony punishable by not more than ten (10) years in prison, a fine of not more than ten thousand dollars (\$10,000.00), or both, and registration of the offender's name on the central registry.

TYPES OF ELDER ABUSE/NEGLECT

- Physical Abuse
- Neglect
- Psychological Abuse
- Fiscal Abuse/Exploitation
- Sexual Abuse

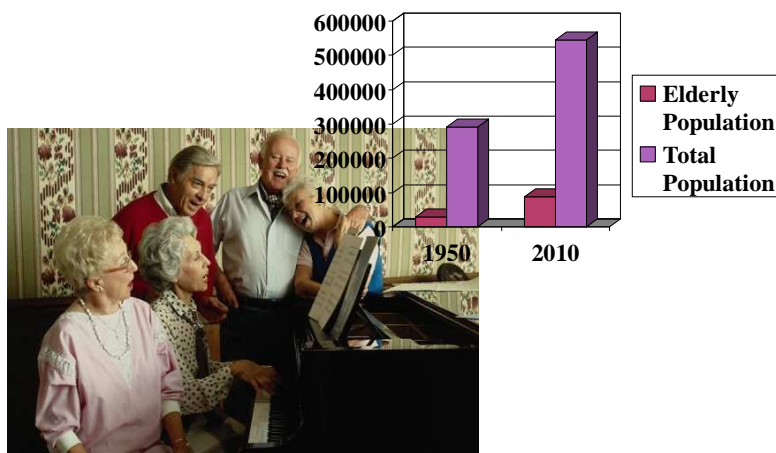
ABUSE IS OFTEN A COMBINATION OF ANY OF THE FIVE BROAD CATEGORIES.

For example, physical abuse is often accompanied by psychological abuse.

TRENDS & CAUSES

- Stress
- Economics
- Vulnerability/Difficulty of Elders
- Working Conditions

GROWING ELDER POPULATION



REFER SUSPECTED FRAUD OR ABUSE
IN MEDICAID FUNDED FACILITIES TO
MFCU.



COORDINATE EFFORTS:

- MFCU
- Law Enforcement - local police, sheriff, DCI
- DFS
- Aging
- Adult Protective Services
- Behavioral Health
- Ombudsmen



WHOSE RESPONSIBILITY IS IT TO INVESTIGATE?

DEPENDS UPON THE NATURE OF COMPLAINT. . .

1. Suspected vulnerable adult abuse or neglect: DFS or Law Enforcement
2. "Resident complaints": Long term care ombudsman
3. Suspected fraud or abuse in Medicaid funded facilities, board and care, or "Other federally funded health care facilities": MFCU
4. Facility issues: Office of Healthcare Licensing & Surveys (OHL&S)
5. Professional licensing issues: Respective Board (Board of Nursing, Medicine, etc.) and/or OHL&S

PROSECUTE

- Criminal Charges & Convictions
- Corporate Liability - Staffing Issues
- Corporate Neglect





RECIPIENT FRAUD

All investigation of fraud perpetrated by Medicaid recipients is conducted by the Department of Family Services' PRICE Unit.

- Prosecution
- Recovery
- Investigation
- Collection
- Enforcement

1-307-777-5481

TPL ISSUES

Medicaid Benefit Recovery Statutes
42-4-201 et seq.

WHERE TO REPORT:
Office of Medicaid
6101 Yellowstone Road
Cheyenne, WY 82002
307-777-7531

CONTACTS



TELEPHONE NUMBERS

- **Medicaid Fraud Control Unit**

- Hot Line 800-378-0345
- Phone 307-777-3444
- Fax 307-777-5094

- **Office of Medicaid**

- Wyoming's State Medicaid Agency 307-777-7531

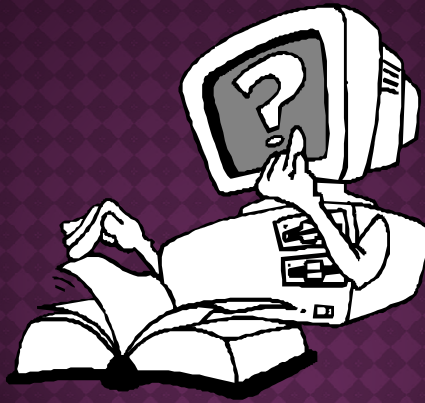
- **ACS**

- Provider Hotline 800-251-1268 or 307-772-8401
- Recipient Hotline 800-251-1269 or 307-772-8402

TELEPHONE NUMBERS CONT.

- Medicare - Office of Inspector General
Cheyenne: 307-772-2230
- Medicare - Social Security Office
Cheyenne: 307-772-2135
- Medicaid Eligibility: contact your local
County DFS Office

ANY QUESTIONS?



**WYOMING MEDICAID FRAUD
CONTROL UNIT**

307-777-3444

800-378-0345

MFCU@STATE.WY.US

